DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for the Correction of
the Coast Guard Record of:

[redacted]

BCMR Docket No. 2014-173

FINAL DECISION

This proceeding was conducted according to the provisions of section 1552 of title 10 and section 425 of title 14 of the United States Code. The Chair docketed the case on July 16, 2014, upon receipt of the completed application and records, and assigned it to staff member [redacted] as required by 33 C.F.R. § 52.61(c).

This final decision, dated April 9, 2015, is approved and signed by the three duly appointed members who were designated to serve as the Board in this case.

APPLICANT'S REQUEST AND ALLEGATIONS

The applicant asked the Board to change the discharge type listed on his DD-214 from medical discharge to medical retirement. He was medically discharged on November 21, 2008, with a 20% disability rating after he accepted the findings of an Informal Physical Evaluation Board and waived his right to a formal hearing. The applicant alleged that the disparity between the 20% rating assigned by the Coast Guard and the Department of Veterans Affairs (DVA) is unjust and currently preventing his retirement with at least a 30% disability.

SUMMARY OF THE RECORD

On February 12, 1999, at the age of 26, the applicant enlisted in the Coast Guard Selected Reserve. During active duty, the applicant was treated for various medical conditions. Only the medical records that concern his disability-related medical conditions (i.e., Obstructive Sleep Apnea, Post-traumatic Stress Disorder, Adjustment Disorder with Depressed Mood, Degenerative/Osteoarthritis, Knee Strain, Degenerative Disc Disease of the Cervical Spine, Bilateral Carpal Tunnel Syndrome, and Hypertension) are included in the summary.

Obstructive Sleep Apnea

The applicant was referred for a sleep study in April 2007. The baseline study was performed on April 10, 2007. The baseline study demonstrated that the applicant has obstructive

sleep apnea[1] with total "RESPIRATORY DISTURBANCE INDEX (RDI)[2] of 45.2." The applicant's symptoms included complaints of daytime hypersomnolence (i.e., excessive sleepiness), witnessed apnea, and snoring. During the sleep study, severe arousals were noted with respiratory events. The applicant snored heavily and loudly throughout the study. No periodic leg movement was noted. At approximately 1:30 a.m., the applicant experienced a panic attack and pulled off all of the recording electrodes. He asked to discontinue the study and left the laboratory.

In the Standard Polysomnography Report, dated April 16, 2007, the Impression is noted as follows:

1) Severe Obstructive Sleep Apnea Syndrome (OSAS) with related arousals. The severity doubled during REM.
2) There was no evidence of Periodic Leg Movement Syndrome (PLMS).
3) There was no evidence of nocturnal hypoxemia.
4) Severe disruption of sleep architecture.
5) Cardiac analysis reveals episodes of bradycardia and tachycardia associated with respiratory events.

On June 29, 2007, the applicant was prescribed a Continuous Air Pressure (CPAP) device and Home Visit for Respiratory Therapy Care.

On May 3, 2007, the applicant was seen at Primary Care [redacted] ISC for a Military Services Physical. Sleep Apnea Obstructive was noted and the applicant was directed to lose weight.

On May 27, 2007, the applicant was referred to Primary Care [redacted] ISC for treatment of Sleep Apnea Obstructive. The Health Record notes that the applicant needed a referral for a TENS[3] unit for a home rehabilitation program and CPAP machine.

Post-Traumatic Stress Disorder (PTSD) /Adjustment Disorder with Depressed Mood

On January 7, 2007, the applicant was seen at Primary Care [redacted] ISC. He was diagnosed with Adjustment Disorder with Depressed Mood and referred to [redacted] ISC Tricare Psychology Clinic for evaluation.

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[1] Apnea means "cessation of breath." Obstructive sleep apnea (OSA) -- also called obstructive sleep apnea syndrome (OSAS) -- occurs when there are repeated episodes of complete or partial blockage of the upper airway during sleep. During an obstructive sleep apnea episode, the diaphragm and chest muscles work harder to open the obstructed airway and pull air into the lungs. Breathing usually resumes with a loud gasp, snort, or body jerk. These episodes can interfere with sound sleep. They can also reduce the flow of oxygen to vital organs and cause irregular heart rhythms.

[2] The respiratory disturbance index (RDI) — or respiratory distress Index — is a formula used in reporting polysomnography (sleep study) findings. Like the apnea-hypopnea index (AHI), it reports on respiratory events during sleep, but unlike the AHI, it also includes respiratory-effort related arousals (RERAs). RERAs are arousals from sleep that do not technically meet the definitions of apneas or hypopneas, but do disrupt sleep. They are abrupt transitions from a deeper stage of sleep to a shallower.

[3] Transcutaneous electrical nerve stimulation (TENS) is the use of electric current to stimulate the nerves for therapeutic purposes. A TENS unit is a device that sends small electrical currents to targeted body parts.

On March 26, 2007, the applicant was seen at Primary Care [redacted] ISC for a follow-up examination to surgery on his right knee. In the applicant's Health Record, the psychotherapist notes that the applicant was receiving stress and anger management counseling.

During a postsurgical examination on July 25, 2007 at the Primary Care [redacted] ISC, the applicant stated that he felt better mentally and emotionally and that his depression symptoms were gradually resolving.

The applicant's record includes a psychotherapist's handwritten note, dated November 5, 2007, which states that the applicant had been in counseling because he was having symptoms of depression, post-traumatic stress disorder[4] and obsessive-compulsive features. The psychotherapist stated that the applicant's symptoms seemed to be related to the applicant's most recent tour of duty and recommended that the applicant continue in therapy to help decrease the stress-related symptoms.

On January 22, 2008, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination. The applicant was given a referral to Psychiatry for symptoms compatible with Depression.

On February 4, 2008, the applicant was seen at Primary Care [redacted] ISC. The primary diagnosis was Depression.

On February 26, 2008, the applicant was prescribed various prescriptions for the treatment of post-traumatic stress disorder and depression.

On March 3, 2008, the applicant was seen at Primary Care [redacted] ISC for "Issue Medical Certificate Fitness." The applicant was found fit for limited duty (FFLD)[5] and ordered to perform desk work only. He was treated for Depression.

On March 10, 2008, at the request of USCG-ISC, the applicant was referred to Mental Health [redacted] for evaluation as part of the applicant's Formal Medical Board process. The applicant was diagnosed with depression with anxiety and panic attacks.

In a memorandum to the U.S. Coast Guard, dated March 13, 2008, the applicant's psychiatrist stated that the applicant had been receiving treatment since February 26, 2008 with a

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[4] Post-traumatic stress disorder (PTSD), once called shell shock or battle fatigue syndrome, is a serious condition that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened. PTSD is a lasting consequence of traumatic ordeals that cause intense fear, helplessness, or horror, such as a sexual or physical assault, the unexpected death of a loved one, an accident, war, or natural disaster. Families of victims can also develop PTSD, as can emergency personnel and rescue workers. Most people who experience a traumatic event will have reactions that may include shock, anger, nervousness, fear, and even guilt. These reactions are common; and for most people, they go away over time. For a person with PTSD, however, these feelings continue and even increase, becoming so strong that they keep the person from living a normal life. People with PTSD have symptoms for longer than one month and cannot function as well as before the event occurred.

[5] Fit for limited duty.

working diagnosis of Post-Traumatic Stress Disorder, Dysthymic Disorder, R/O[6] Major Depressive Disorder. The psychiatrist noted that the applicant had been prescribed Cymbalta 30 mg. a day and Seroquel 25 mg. at bed time for the PTSD and Dysthymic Disorder, as well as Ativan .5 mg prn for anxiety.

On March 24, 2008, the applicant consulted with a psychiatrist for anxiety and depression. The psychiatrist recommended that the applicant continue psychotherapy and taking prescribed medications.

In a written response to a questionnaire requested by the applicant's attorney, the psychiatrist stated that the applicant was receiving treatment due to severe anxiety disorder he claimed he developed while on active duty, serving in the Middle East. The psychiatrist noted that the anxiety interfered with the applicant's ability to concentrate and memorize. Therefore, his ability to perform his occupational tasks was impaired. The applicant reported being in a constant state of alert for fear of losing control in the event any comments may trigger a flashback. The psychiatrist further noted that the applicant's symptoms were very frequent and may occur even in mild periods of stress. The psychiatrist made the following conclusions:

1) His poor attention span and lack of concentration may interfere in any emotional and extensive evaluation of any type.
2) During the examination, the applicant's anxiety is notable; however, the flashbacks and any other mechanism his brain has developed may be noted during more intense periods of stress.
3) No hospitalization has been required since [the psychiatrist is] attending his case.
4) [Applicant experiences anxiety] possibly more than 50% of the time.
5) Job stability is extremely unstable.
6) Social adjustment is significantly impaired.
7) Requires medication daily.
8) Requires psychotherapy at least weekly and psychotropic monitoring at least once monthly.
9) Presents a low existent danger to others, only in periods where he is exposed to severe stress and he experiences flashbacks.

Degenerative Arthritis (Osteoarthritis) [7] *(Right Knee)*

In a Report of Medical Examination dated January 5, 1999, the applicant noted that the he sustained a right knee injury playing football. However, no record of the injury or treatment is available.

A Magnetic Resonance Imaging Report from Hadi Clinic Medical Imaging Department, dated March 8, 2006, notes an Impression of mild joint effusion and complete ACL[8] tear of the applicant's right knee.

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[6] "R/O" means that the condition may exist and needs to be "ruled out."

[7] Degenerative arthritis, also known as osteoarthritis and degenerative joint disease, is a type of arthritis caused by inflammation, breakdown, and eventual loss of the cartilage of the joints. Degenerative arthritis is the most common form of arthritis, usually affecting the hands, feet, spine, and large weight-bearing joints, such as the hips and knees. Symptoms may include joint pain, tenderness, stiffness, locking, and sometimes an effusion. The main cause is limb misalignment, combined with hereditary, developmental, and metabolic factors, which leads to loss of cartilage, sometimes exposing and damaging the underlying bone. Pain makes it difficult to exercise, so muscles may atrophy.

[8] An anterior cruciate ligament, or ACL, injury is a tear in one of the knee ligaments that joins the upper leg bone with the lower leg bone. The ACL keeps the knee stable.

On August 1, 2006 at [redacted], the applicant received an MRI to evaluate right knee pain that he had endured for two weeks following a "slip and fall" on a wet floor, during which the right knee "buckled out." The injury caused pain to the ACL and MCL[9] regions. In the Chronological Record of Medical Care, the applicant stated that he had undergone two MCL and ACL surgeries to the same knee approximately two years before.

On September 20, 2006, the applicant was seen at Primary Care [redacted] ISC for pain in his right knee and right shoulder. The diagnosis was Knee Sprain Cruciate Ligament Anterior Right and Shoulder Sprain. The applicant was also evaluated for Hypertension and prescribed Lisinopril.

On November 27, 2006, the applicant was seen at Othopaedic Center [redacted], [redacted] He received and X-ray and MRI of his right knee. The record notes that the applicant had undergone two previous arthroscopic surgeries on his right knee. The Impression is noted as anterior cruciate ligament insufficiency with medial meniscal tear.

On November 30, 2006, the applicant was seen at Primary Care [redacted] ISC for right knee pain. The diagnosis was Knee Sprain Cruciate Ligament Anterior Right.

On January 11, 2007, the applicant was seen at Primary Care [redacted] ISC. He was diagnosed with Localized Joint Pain in the Knee.

On January 19, 2007, the applicant was seen at Primary Care [redacted] ISC for an ACL tear. He was diagnosed with Knee Sprain Cruciate Ligament Anterior Right and released without limitations.

On January 30, 2007, Chief Health Services sent a memorandum to a Coast Guard physician with the subject heading "Medical Clearance for [Applicant]." The memorandum notes that the applicant had an ACL tear and hypertension. The clinical diagnosis was ACL tear and the indications for procedure were repair ACL right knee. The applicant was "medically cleared for procedure."

On February 6, 2007, the applicant was referred to Primary Care [redacted] ISC for consultation regarding his knee pain. The diagnosis was Knee Sprain Cruciate Ligament Anterior.

On January 31, 2007, the applicant underwent surgery to repair the ACL in his right knee.

On February 21, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee.

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[9] The medial collateral ligament (MCL or tibial collateral ligament) is one of the four major ligaments of the knee. The MCL runs down the inner side of the knee, connecting the shinbone (tibia) to the thighbone (femur). In conjunction with other knee ligaments, the MCL stabilizes the knee and prevents over-extension.

On March 26, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that the applicant was wearing a special knee brace; and according to the surgeon the applicant will need to wear the knee brace for life. The applicant has two 1.5" screws above and below the knee, which causes a lot of discomfort. The applicant stated that he was not taking the prescribed pain medications because he did not like the side effects. The Health Record also notes that the applicant was attending physical therapy three times per week.

On May 7, 2007, the applicant was seen at Primary Care [redacted] ISC for a Military Services Physical. Old Disruption of Anterior Cruciate Ligament of the Right Knee was noted. The applicant was referred for a TENS unit.

On July 12, 2007, the applicant was seen at Primary Care [redacted] ISC for Knee Sprain Cruciate Ligament Anterior Right. He was referred to Orthopedics for a knee brace.

On July 25, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that the applicant stated his "right knee [was] doing ok after surgery and rehab."

On October 17, 2007, the applicant was seen at Primary Care ISC to receive a knee brace. Old Disruption of Anterior Cruciate Ligament of the Right Knee was noted.

On October 28, 2008, the applicant was seen at Primary Care [redacted] ISC for pain in both knees. The applicant complained of left knee pain and wore a brace on his right knee. The primary diagnosis was Patellofemoral Syndrome[10] in the right knee and R/O vs Chondromalacia Patella[11].

Left Knee Strain[12]/Internal Derangement of Knee Medial Meniscus

On May 4, 2000, the applicant was seen at Primary Care USCG [redacted] for left knee pain. The Radiologic Examination Report indicates that the applicant injured his knee while playing softball on Sunday, May 2, 2000. There was no evidence of fracture or dislocation. No degenerative change was noted nor effusion seen. No radiopaque intra-joint foreign body was present.

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[10] Patellofemoral pain syndrome (PFPS) is a syndrome characterized by pain or discomfort seemingly originating from the contact of the posterior surface of the patella (back of the kneecap) with the femur (thigh bone).

[11] Chondromalacia patella develops due to softening and damage to the kneecap cartilage.

[12] A knee strain is an acute injury in which tendons and ligaments become stretched or torn. Most strains occur because of direct blows to the knee, extreme bending or twisting of joints, or overuse through repetitive activity. The most common symptoms include pain, swelling, loss of mobility, and a lack of strength. Depending on the severity of a knee strain, an individual may be able to ease symptoms and recover with rest and simple home remedies. A serious strain usually requires immediate medical attention, surgery, and several weeks of physical therapy. Knee tendons and ligaments connect muscles to leg bones, provide stability, and allow the knee joint to move and bend. The anterior cruciate ligament (ACL) is an especially large, important ligament that is commonly strained in sports and other physical activities. The ACL and nearby tendons can be injured when the knee strikes the ground, or when a sudden twist extends the joint beyond its normal range of motion. Strains can also result from repetitive activity, such as lifting heavy objects or frequently sprinting and stopping.

On January 7, 2007, the applicant was seen at Primary Care [redacted] ISC for left knee pain with crepitus[13] as he stated he favored the right knee while walking. The applicant stated that he only walked for short periods of time at a very low pace and was unable to drive.

On January 24, 2007, the applicant was seen at OMI Medical Imaging for MRI testing of his left knee. The positive findings were: 1) small joint fluid collection; 2) mild myxoid changes, medial and lateral menisci; 3) minimal soft tissue edema; and 4) some slight change on the Short Tau Inversion Recovery (STIR)[14] sequence along the medial collateral ligament, which may reflect a degree of minimal inflammatory change/grade 1 sprain.

On July 25, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that, according to Orthopedics, the applicant was recommended for left knee surgery, but the date had not been scheduled at that time.

On October 28, 2008, the applicant was seen at Primary Care [redacted] ISC for pain in both knees. The applicant complained of left knee pain and wore a brace on his right knee. The primary diagnosis was Patellofemoral Syndrome in the right knee and R/O vs Chondromalacia Patella. The applicant was also seen at Radiology Resource, Inc. for an examination of his left knee. The Impression noted is "no acute process."

In an Initial Orthopaedic Evaluation from MD P.A. dated October 28, 2008, the physician notes that the applicant had point tenderness over the left knee with generalized pain along the medial side of the patella, radiating down the medial joint line and below the knee joint towards the proximal tibial metaphysis. The Impression noted is "acute chondromalacia of the patellofemoral joint and pes anserinus bursitis[15] of the left knee."

Osteoarthritis (Right Shoulder)

On May 4, 2000, the applicant was seen at Primary Care USCG [redacted] for right arm weakness. The Radiologic Examination Report indicates that the applicant injured arm while playing softball on Sunday, May 2, 2000.

In a Health Record dated May 4, 2006, the applicant complained of right shoulder pain that he endured for several weeks. He stated he was hit to the ground with another crew member

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[13] A clinical sign in medicine that is characterized by a peculiar crackling, crinkly, or grating feeling or sound under the skin, around the lungs, or in the joints. Crepitus in soft tissues is often due to gas, most often air, that has penetrated and infiltrated an area where it should not normally be (for example, in the soft tissues beneath the skin). Crepitus in a joint can indicate cartilage wear in the joint space.

[14] Fat suppression is the process of utilizing specific MRI parameters to remove the deleterious effects of fat from the resulting images. STIR is an MRI term for a specialized application of the inversion recovery pulse sequence which sets the inversion time (TI) of the sequence at 0.69 times the T1 of fat, thereby suppressing the fat in the image.

[15] Pes anserinus bursitis is an inflammatory condition of the medial knee at the anserine bursa, a sub muscular bursa, just below the pes anserinus.

falling on him with all of his body weight causing the applicant to land on his right shoulder. The diagnoses were 1st degree AC separation and DDX[16]-Bursitis.

On July 26, 2006 at [redacted], the applicant was seen for shoulder pain that lasted for two months. In the Chronological Record of Medical Care, the applicant stated he injured his right shoulder while serving in [redacted] in Bahrain when he was hit to the ground by another crew member causing him to land on his right shoulder. The diagnosis was Bursitis[17].

On October 12, 2006, the applicant was seen at OMI Medical Imaging for an MRI of his right shoulder. The positive findings were: 1) an element of underlying cuff tendinosis; 2) capsular prominence and spurring, acromioclavicular joint; 3) small component of subacromial-subdeltoid bursal fluid/peritendinous inflammation; and 4) mild reactive/subcortical cystic change superolateral humeral head.

On October 30, 2006, the applicant was seen at Primary Care [redacted] ISC for right shoulder pain. The diagnosis was Tendonitis Rotator Cuff. The Chronological Record of Medical Care states that the applicant did not want to take any medication.

On November 27, 2006, the applicant was seen at Othopaedic Center [redacted], [redacted] He received and X-ray and MRI of his right shoulder. The Impression noted is possible labral injury in right shoulder.

On November 30, 2006, the applicant was seen at Primary Care [redacted] ISC for right shoulder pain. The diagnosis was Tendonitis Rotator Cuff.

On December 12, 2006, the applicant was examined at [redacted] Tests included an injection arthrogram and MRI with contrast of the right shoulder. The tests revealed evidence of partial tearing of the supraspinatus tendon and anterior infraspinatus tendon along the distal aspect. The Impression noted is: 1) a partial tear of the undersurfaces of the rotator cuff more posterior in the posterior supraspinatus tendon and anterior and central infraspinatus tendon; 2) mild subdeltoid bursitis; and 3) labral blunting and fraying posterosuperiorly with a small linear tear within the substance of the labrum in the mid to inferior posterior aspect without separation and detachment.

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[16] In medicine, a differential diagnosis (DDX) is the distinguishing of a particular disease or condition from others that present similar symptoms. Differential diagnostic procedures are used by physicians and other trained medical professionals to diagnose the specific disease in a patient, or, at least, to eliminate any imminently life-threatening conditions. Often each individual option of a possible disease is called a differential diagnosis (for example, bronchitis could be a differential diagnosis in the evaluation of a cough that ends up with a final diagnosis of common cold). More generally, a differential diagnostic procedure is a systematic diagnostic method or process of elimination used to identify the presence of an entity where multiple alternatives are possible.

[17] Bursitis is a painful condition that affects the small, fluid-filled sacs – called bursae – that cushion the bones, tendons and muscles near your joints. Bursitis occurs when bursae become inflamed. The most common locations for bursitis are in the shoulder, elbow and hip. But you can also have bursitis by your knee, heel and the base of your big toe. Bursitis often occurs near joints that perform frequent repetitive motion. Treatment typically involves resting the affected joint and protecting it from further trauma. In most cases, bursitis pain goes away within a few weeks with proper treatment, but recurrent flare-ups of bursitis are common.

On January 7, 2007, the applicant was seen at Primary Care [redacted] ISC. He complained of right hand parethesia[18]. The diagnosis was Shoulder Joint Disorder.

On January 2, 2007, the applicant was seen at Orthopaedic Center [redacted] for a follow-up visit. MRI testing revealed Cervical Radiculitis versus Ulnar Neuritis, partial tear of the right rotator cuff, and a small posterior labral tear.

On January 11, 2007, the applicant was seen at Primary Care [redacted] ISC. He was diagnosed with Localized Joint Pain in the Shoulder.

In a letter from a physician at [redacted] Neurology Department, dated March 21, 2007, the physician noted that the applicant had been referred to him for evaluation of joint aches and pain and numbness and tingling in his right shoulder.

On March 26, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that the applicant was experiencing shoulder pain. He was scheduled for an MRI of the upper extremities and cervical spine on April 10, 2007.

On May 16, 2007, the applicant was seen at Primary Care [redacted] ISC for physical therapy consultation for treatment of Compression Arthralgia[19] of the Shoulder Region was noted.

On May 27, 2007, the applicant was referred to Primary Care [redacted] ISC – Orthopedics for treatment of Tendonitis Rotator Cuff.

On July 25, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that, according to Orthopedics, the applicant was recommended for right shoulder surgery, but the date had not been scheduled at that time.

On November 7, 2007, the applicant was seen at [redacted] Orthopedic Clinic for an opinion regarding his multiple musculoskeletal issues. The applicant stated that his knee felt stable and he had very little pain. The applicant also stated that he had been to physical therapy for his shoulder with little relief. An MRI of the right shoulder revealed a partial thickness rotator cuff tear and a Superior Labrum Anterior Posterior (SLAP) tear. The diagnosis was joint pain, localized in the shoulder, rotator cuff tendonitis, partial tear, probably SLAP tear. The physician recommended surgical intervention and therapy to relieve the applicant's shoulder pain.

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[18] Parethesia is an abnormal sensation, typically tingling or pricking ("pins and needles"), caused chiefly by pressure on or damage to peripheral nerves.

[19] Compression arthralgia is pain in the joints caused by exposure to high ambient pressure at a relatively high rate of compression, experienced by underwater divers. It is also referred to in the US Navy diving Manual as compression pains.

On November 28, 2007, the applicant was referred to Primary Care [redacted] ISC for surgery consultation regarding the SLAP tear in his right shoulder.

In a memorandum dated November 13, 2007, Chief Health Services stated that the applicant was "medically cleared for surgery."

On December 5, 2007, the applicant was seen at Orthopaedic Center [redacted] for a follow-up examination. The Impression noted is right shoulder impingement with partial thickness, rotator cuff tear, and possible labral tear.

On December 14, 2007, the applicant was referred to Primary Care [redacted] ISC for treatment of right shoulder pain.

On January 4, 2008, the applicant was seen at Orthopaedic Center [redacted] for a follow-up examination. The Impression noted is right shoulder impingement with partial thickness, rotator cuff tear, and possible labral tear.

On January 7, 2008, the applicant was referred to Primary Care [redacted] ISC for treatment of right shoulder pain. The Health Record notes that the surgeon requested cold therapy and an antibiotic. However, Tricare did not approve the cold therapy and the applicant was referred to [redacted] ISC Tricare – Physical Medicine & Rehabilitation for physical therapy. The primary diagnosis was Shoulder Impingement.

On January 8, 2008, the applicant underwent surgery to repair the SLAP tear in his right shoulder.

On January 14, 2008, the applicant was seen at Orthopaedic Center [redacted] for a postsurgical examination. The Impression is noted as status post right shoulder arthroscopy, debridement of the superior labrum and undersurface, partial thickness of the rotator cuff, subacromial decompression. The record notes that the applicant was "out of work at this time" and "on medical leave from the military."

On January 22, 2008, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of the right shoulder. The Health Record notes that the applicant's condition seemed to be improving as the symptoms prior to surgery were resolving.

Degenerative Disc Disease of the Cervical Spine[20]

[20] Degenerative disc disease is a general term for the condition in which a damaged vertebral disc causes chronic pain – either low back pain (and/or leg pain, sciatica) in the lumbar spine or neck pain (and/or arm pain) in the cervical spine. Damage to the disc occurs naturally or through a twisting injury where the inner and/or outer portions of the disc may tear, exposing or irritating the nerves on the outer edge of the annulus. The injury can also create excessive micro-motion instability at the adjacent vertebrae because the disc cannot hold the vertebral segment together as well as it used to. The disc itself has very few nerve endings and no blood supply. Without a blood supply the disc does not have a way to repair itself, and pain created by the damaged disc can last for years, either as a chronic condition or with periodic painful flare ups. The symptoms are most common in individuals, who are age 30 to 60 years old.

On January 11, 2007, the applicant was seen at Primary Care [redacted] ISC. He was referred for consultation for Cervical Radiculopathy[21]. He was released without limitations.

On March 26, 2007, the applicant was seen at Primary Care [redacted] ISC for postsurgical examination of his right knee. The applicant's Health Record notes that the applicant was experiencing cervical pain. He was scheduled for an MRI of the upper extremities and cervical spine on April 10, 2007.

On April 10, 2007, the applicant was seen at [redacted]. for right hand and shoulder numbness. MRI testing revealed Cervical Spondylosis with Multilevel Degenerative Disc Disease.

In a letter from a physician at [redacted] Neurology Department, dated April 24, 2007, the physician noted that the applicant continued to have pain in his neck and right shoulder and numbness in both hands.

On May 16, 2007, the applicant was seen at Primary Care ISC for physical therapy consultation to treat Cervical Radiculopathy.

Left Carpal Tunnel Syndrome (non-dominant)[22]

On April 30, 2007, the applicant was seen at Primary Care [redacted] ISC for shoulder pain. He was diagnosed with Carpal Tunnel Syndrome in the left hand. He was issued a wrist brace to wear at "Sick at Home". The applicant was instructed to follow-up with Primary Care [redacted] in two days or sooner if there were problems.

On May 3, 2007, the applicant was seen at Primary Care [redacted] ISC for a Military Services Physical, during which time Mild Bilateral Carpal Tunnel Syndrome was noted.

Right Carpal Tunnel Syndrome (dominant)

In a letter from a physician at [redacted] Neurology Department, dated March 21, 2007, the physician noted that the applicant had been referred to him for evaluation of joint aches and pain and numbness and tingling in his right hand. He was diagnosed with Bilateral Carpal Tunnel Syndrome.

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[21] Cervical radiculopathy is pain starting in the upper spine (neck) that causes pain, numbness, or weakness in the neck and going down the arm or arms.

[22] Carpal tunnel syndrome is a hand and arm condition that causes numbness, tingling and other symptoms. Carpal tunnel syndrome is caused by a pinched nerve in your wrist. A number of factors can contribute to carpal tunnel syndrome, including the anatomy of your wrist, certain underlying health problems and possibly patterns of hand use. Bound by bones and ligaments, the carpal tunnel is a narrow passageway located on the palm side of your wrist. This tunnel protects a main nerve to your hand and the nine tendons that bend your fingers. Compression of the nerve produces the numbness, tingling and, eventually, hand weakness that characterize carpal tunnel syndrome. Fortunately, for most people who develop carpal tunnel syndrome, proper treatment usually can relieve the tingling and numbness and restore wrist and hand function.

On May 3, 2007, the applicant was seen at Primary Care [redacted] ISC for a Military Services Physical. Mild Bilateral Carpal Tunnel Syndrome was noted and the condition was worse in the applicant's right hand. The applicant was given splints for both hands and referred for physical therapy.

On May 16, 2007, the applicant was seen at Primary Care [redacted] ISC for physical therapy consultation to treat carpal tunnel syndrome.

Hypertension

On September 20, 2006, the applicant was seen at Primary Care [redacted] ISC. His blood pressure was 146/112. He was prescribed Lisinopril for hypertension.

On November 30, 2006, the applicant was seen at Primary Care [redacted] ISC. His blood pressure was 147/110. The applicant stated that he had not been taking the high blood pressure medication prescribed during a previous visit.

On January 10, 2007, the applicant was seen at Primary Care [redacted] ISC. His blood pressure was 144/103. He was diagnosed with Essential Hypertension and prescribed Norvasc.

During a postsurgical examination on March 26, 2007, the applicant was given a refill of Norvasc for treatment of blood pressure. The applicant's Health Record notes that the applicant modified his diet to control his blood pressure and weight.

During a postsurgical examination on July 25, 2007, the applicant stated that he had stopped taking Norvasc about three weeks prior to the examination and that his knee conditions made it difficult for him to exercise.

Coast Guard Physical Disability Evaluation Board Findings and Recommended Disposition

On July 3, 2008, the applicant was seen at [redacted] VAMC for general medical examination. The Compensation and Pension Exam Report dated July 22, 2008 provides the following Impressions and Diagnoses:

> Impressions:
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> 1. He has hypertension which is essential.
> 2. He has sleep apnea. He does have a continuous airway pressure machine.
>
> Diagnoses:
>
> 1. Bilateral Carpal Tunnel Syndrome
>
>   Repetitive motions of the patient's wrist and fingers will have no effect on the patient's range of motion, pain, fatigability, weakness or endurance.
>
> 2. Chronical cervical strain with degenerative spondyloarthritis and degenerative disc disease C6-C7.

Opinion whether there will be any further decrease of the range of motion during the flare-ups would be based on speculation and for this reason no opinions are given.

3. Status post shoulder repair and decompression of the right shoulder.
4. Early osteoarthritic changes of the right shoulder.
5. Right knee is status post repair of anterior cruciate ligament and chondroplasty. Mild degenerative changes in the patellorfemoral joint andmedial tibiofemoral joint.
6. Left knee is chronic strain of the left knee.

Repetitive motions of the patient's shoulders and knees have no effect on the patient's range of motion, pain, fatigability, weakness or coordination, or endurance.

Opinions whether there will be any further decrease of the range of motion during the flare-ups would be based on speculation and for this reason no opinions are given.

On July 9, 2008, the applicant was seen at [redacted] VAMC for Compensation and Pension Exam. The Diagnosis was PTSD Initial: Mental Competency.

On October 3, 2008, the Coast Guard Informal Physical Evaluation Board (IPEB) issued its tentative findings and recommended disposition regarding the applicant's disability status. In the findings, the IPEB noted that applicant incurred several disabling medical conditions while he was entitled to receive basic military pay and that these conditions were not a result of willful neglect, intentional misconduct, or during unauthorized absence. The applicant's medical conditions included limited range of motion and osteoarthritis in the right shoulder and right knee with X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups. The IPEB further determined that the applicant's medical conditions were the proximate result of the applicant's performance of active duty or inactive duty training, or incurred in the line of duty during war or national emergency. The IPEB also found that the applicant's medical conditions to be permanent, combat-related, and the result of instrumentality of war. IPEB concluded that substantial evidence demonstrated that the applicant was physically and/or mentally unfit to perform regular or customary assigned duties.

In an Amplifying Statement, the IPEB stated that the board had carefully considered the diagnoses reported on the Medical Board Report Cover Sheet (CG-5684) dated May 23, 2007 and addendum dated August 20, 2007. By a preponderance of the evidence the board found that the applicant was unfit for continued duty by reason of physical disability. Two unfitting conditions were identified and rated:

Medical Description	Percent (%) Assigned
Acromioclavicular Arthrosis[23] of the right shoulder	10%
Right knee, stable	10%

[23] Acromioclavicular (AC) joint arthrosis is a common degenerative disorder that can lead to pain and difficulty during everyday use of the shoulder. The acromion is the part of the scapula that makes up the roof of the shoulder; it connects with the clavicle at the AC joint. In addition, the AC joint is particularly prone to the development of osteoarthritis during middle age. This condition contributes to its onset.

Both conditions were rated at 10 percent. However, the applicant received a combined disability rating of 19%, rounded to 20%. The IPEB recommended a disposition of separation with severance pay.

On October 10, 2008, the applicant acknowledged and accepted the tentative IPEB findings and recommended disposition and waived his right to a formal hearing.

On October 16, 2008, CAPT, USCG, CGPC-ADH, Final Approving Authority (for the Commandant), approved the IPEB findings and recommended disposition.

Effective November 21, 2008, the applicant was discharged from the Coast Guard with Honorable Character of Service, Separation Code MBK, Reentry Code RE-1, and Physical Disability as the Narrative Reason for Separation.

DVA Disability Rating

On July 31, 2009, the DVA [redacted] Regional Office issued a Certificate to the applicant to use in establishing civil service preference. The Certificate is considered a permanent record of the applicant's service-connected disabilities and verifies that the applicant is entitled to compensation for service-connected disabilities rated at 30 percent or more. The DVA determined that the following conditions were related to the applicant's military service, so connection was granted as follows:

Medical Description	Percent (%) Assigned	Effective Date
Obstructive sleep apnea	50%	Nov 22, 2008
Post-traumatic stress disorder	50%	Nov 22, 2008
Degenerative arthritis of the right knee	10%	Nov 22, 2008
Osteoarthritis of the right shoulder (dominant)	10%	Nov 22, 2008
Left knee strain	10%	Nov 22, 2008
Degenerative disc disease of the cervical spine	10%	Nov 22, 2008
Hypertension	0%	Nov 22, 2008
Left carpal tunnel syndrome (non-dominant)	0%	Nov 22, 2008
Right carpal tunnel syndrome (dominant)	0%	Nov 22, 2008

The DVA report notes that the individual averages of each condition are not added to determine the combined rating. Rather, the DVA uses a combined rating table that considers the effect from the most serious to the least serious conditions. The applicant was given an overall rating of 80%.

VIEWS OF THE COAST GUARD

On September 12, 2014, Commander, Personnel Service Center (PSC) sent a memorandum to the Judge Advocate General (JAG) of the Coast Guard in which PSC concluded that the applicant was discharged from the Coast Guard in 2008; therefore, his application is not timely. In its Discussion/Conclusions, the JAG opined that the applicant has the burden of proving by a preponderance of the evidence that an error or injustice has occurred. Furthermore, the Coast Guard is presumed to have acted properly, legally, and in good faith in its review and adjudication of this matter. In disability discharge cases, the Coast Guard uses the Veterans Affairs Schedule for Rating Disabilities (VASRD) to rate the disabling conditions of its members. The Physical Evaluation Board (PEB) is the expert administrative body charged by law with the performance of the evaluation and rating function of military service members. Courts generally will not substitute their own judgment for that of the PEB (i.e., expert administrative body charged by law with the performance of the evaluation and rating function.) Therefore, the JAG concluded that the Coast Guard Informal Physical Evaluation Board's (IPEB) findings reflect an accurate report of the applicant's unfit conditions and rated them appropriately at 20%. The Board found that the applicant was Not Fit for Duty. Moreover, the applicant had the option to dispute these results and request a formal hearing or FPEB. The noted in the applicant's records, the applicant chose rather to accept the IPEB findings, thus waiving his right to a formal hearing.

On December 24, 2014, the JAG submitted an advisory opinion adopting the facts and analysis in PSC's memorandum and requested the Board to accept his comments as the Coast Guard's advisory opinion. The JAG found no evidence sufficient to overcome the presumption of regularity that the applicant suffered from any service unfitting conditions beyond those for which he was rated by the Informal Physical Evaluation Board. The JAG recommended that the Board deny relief in accordance with PSC recommendation.

APPLICANT'S RESPONSE TO THE VIEWS OF THE COAST GUARD

On January 16, 2015, the Chair sent the applicant a copy of the views of the Coast Guard and invited him to respond within thirty days. The Board did not receive a response.

APPLICABLE POLICY

Disability Statutes

Title 10 U.S.C. § 1201 provides that a member who is found to be "unfit to perform the duties of the member's office, grade, rank, or rating because of physical disability incurred while entitled to basic pay" may be retired if the disability is (1) permanent and stable, (2) not a result of misconduct, and (3) for members with less than 20 years of service, "at least 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination."

Title 10 U.S.C. § 1203 provides that such a member whose disability is rated at only 10 or 20 percent under the schedule shall be discharged with severance pay.

Provisions of the Medical Manual (COMDTINST M6000.1B)

Chapter 3.A.19.c.(1) states that myofascial syndrome may be disqualifying "when not controlled by medication or with reliably diagnosed depression."

Chapter 3.B.5. provides that when an officer objects to a finding of qualified for separation or release, CGPC will review the record to make a final determination as to whether the officer will be separated or processed under the PDES.

Chapter 3.B.5.a. of the Medical Manual states that any member undergoing separation from the service who disagrees with the assumption of fitness for duty and claims to have a physical disability shall submit written objections within 10 days of signing the chronological record of service to CGPC. The member is responsible for submitting copies of the following along with written objections: (1) report of medical examination (SF-88); (2) Report of Medical History (SF-93); signed copy of chronological record of service (CG-4057); (4) appropriate consultations and reports; and (5) other pertinent documentation.

Chapter 3.B.5.b. states that consultations shall be obtained to thoroughly evaluate all the problems or objections indicated by the evaluee. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.

Chapter 3.B.5.c. states that CGPC will evaluate each case and, based upon the information submitted, take one of the following actions: (1) find separation appropriate, in which case the individual will be so notified and the normal separation process completed; (2) find separation inappropriate, in which case the entire record will be returned and appropriate action recommended; or (3) request additional documentation before making a determination.

Chapter 3.B.6. provides that "[w]hen a member has an impairment (in accordance with section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b) [of the PDES Manual] are also met. Otherwise the member is suitable for separation."

Chapter 3.F. of the Medical Manual provides that members with medical conditions that are disqualifying for retention in the Service shall be referred to an IMB by their commands. Chapter 3.F.1.c. of the Medical Manual states that members "are ordinarily considered fit for duty unless they have a physical impairment (or impairments) which interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties."

Chapter 3.F.12. provides the minimum ranges of motion that each party of the body must have for retention on active duty.

Chapter 3.F.13.c. provides that back pain caused by a herniated disc may be disqualifying if there are "[m]ore than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty."

Chapter 3.F.15.n.(1) states that neuralgia (nerve pain) may be disqualifying when "symptoms are severe, persistent, and not responsive to treatment." Article 3.F.15.n.(2) states that neuritis (inflammation of a nerve causing pain and numbness) may be disqualifying when "manifested by more than moderate, permanent functional impairment."

Provisions of the PDES Manual (COMDTINST M1850.2C)

Chapter 2.A.15. of the PDES Manual defines "fit for duty" as "[t]he status of a member who is physically and mentally able to perform the duties of office, grade, rank or rating."

Chapter 2.A.38. defines "physical disability" as "[a]ny manifest or latent physical impairment or impairments due to disease, injury, or aggravation by service of an existing condition, regardless of the degree, that separately makes or in combination make a member unfit for continued duty."

Chapter 2.C.2. states the following:

> b. The law that provides for disability retirement or separation (10 U.S.C., chapter 61) is designed to compensate members whose military service is terminated due to a physical disability that has rendered him or her unfit for continued duty. That law and this disability evaluation system are not to be misused to bestow compensation benefits on those who are voluntarily or mandatorily retiring or separating and have theretofore drawn pay and allowances, received promotions, and continued on unlimited active duty status while tolerating physical impairments that have not actually precluded Coast Guard service. The following policies apply.
>
> (1) Continued performance of duty until a service member is scheduled for separation or retirement for reasons other than physical disability creates a presumption of fitness for duty. This presumption may be overcome if it is established by a preponderance of the evidence that:
>
> (a) the member, because of disability, was physically unable to perform adequately in his or her assigned duties; or
>
> (b) acute, grave illness or injury, or other deterioration of the member's physical condition occurred immediately prior to or coincident with processing for separation or retirement for reasons other than physical disability which rendered the service member unfit for further duty.
>
> (2) A member being processed for separation or retirement for reasons other than physical disability shall not be referred for disability evaluation unless the conditions in paragraphs 2.C.2.b.(1)(a) or (b) are met.
>
> c. If a member being processed for separation or retirement for reasons other than physical disability adequately performed the duties of his or her office, grade, rank or rating, the member is presumed fit for duty even though medical evidence indicates he or she has impairments.
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> • • •
>
> f. The following standards and criteria will not be used as the sole basis for making determinations that an evaluee is unfit for continued military service by reason of physical disability.
>
> (1) Inability to perform all duties of his or her office, grade, rank or rating in every geographic location and under every conceivable circumstance. …

> (2) Inability to satisfy the standards for initial entry into military service… .
>
> • • •
>
> (4) Inability to qualify for specialized duties requiring a high degree of physical fitness, such as flying… .
>
> (5) The presence of one or more physical defects that are sufficient to require referral for evaluation or that may be unfitting for a member in a different office, grade, rank or rating.
>
> (6) Pending voluntary or involuntary separation, retirement, or release to inactive status.

Chapter 2.C.2.a. provides that the "sole standard" that a CPEB[24] (or FPEB) may use in "making determinations of physical disability as a basis for retirement or separation shall be unfitness to perform the duties of office, grade, rank or rating because of disease or injury incurred or aggravated through military service."

Chapter 2.C.3.a.(3)(a) provides that, if a CPEB (or subsequently an FPEB) finds that the member is unfit for duty because of a permanent disability, it will propose a physical disability rating. The CPEB shall—

> propose ratings for those disabilities which are themselves physically unfitting or which relate to or contribute to the condition(s) that cause the evaluee to be unfit for continued duty. The board shall not rate an impairment that does not contribute to the condition of unfitness or cause the evaluee to be unfit for duty along with another condition that is determined to be disqualifying in arriving at the rated degree of incapacity incident to retirement from military service for disability. In making this professional judgment, board members will only rate those disabilities which make an evaluee unfit for military service or which contribute to his or her inability to perform military duty.

Chapter 4.A.14.c. provides that if the member objects to a CPEB finding, he may demand a formal hearing by the FPEB.

Chapter 3 provides that if a member's fitness for continued duty is in question, an IMB of two medical officers shall conduct a thorough medical examination, review all available records, and issue a report with a narrative description of the member's impairments, an opinion as to the member's fitness for duty and potential for further military service, and if the member is found unfit, a referral to a Central Physical Evaluation Board (CPEB). The member is advised about the PDES and permitted to submit a response to the IMB report.

Chapter 3.D.7. states that a "member who is being processed for separation…shall not normally be referred for physical disability evaluation. … [A]bsence of a significant decrease in the level of a member's continued performance up to the time of separation or retirement satisfies the presumption that the member is fit to perform the duties of his or her office, grade, rank or rating (see paragraph 2.C.2.)."

Chapter 4 provides that a CPEB shall review the IMB report, the CO's endorsement, and the member's medical records.

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[24] In 2006, the Coast Guard began referring to CPEBs (Central Physical Evaluation Boards) as IPEBs (Informal Physical Evaluation Boards) to conform to DOD nomenclature, but the manual in effect was not immediately updated.

Chapter 5.C.11.a. provides that the FPEB shall issue findings and a recommended disposition of each case in accordance with the provisions of Chapter 2.C.3.a. (see above). The applicant may submit a rebuttal within 15 working days, and the FPEB must respond and, if indicated, prepare a new report. The FPEB's final report is reviewed for sufficiency by an officer at CGPC and by the Judge Advocate General, and forwarded to the Chief of the Administrative Division of CGPC for final action.

DoD Instruction 1332.39

Paragraph E2.A1.1.20.2. of Enclosure 2 of this instruction, which the Coast Guard uses as non-binding guidance, states with respect to a member's back pain that "[d]emonstrable pain on spinal motion associated with positive radiographic findings shall warrant a 10 percent rating. If paravertebral muscle spasms are also present, a 20 percent rating may be awarded. Such paravertebral muscle spasms, however, must be chronic and evident on repeated examinations."

FINDINGS AND CONCLUSIONS

The Board makes the following findings and conclusions on the basis of the applicant's military record and submissions, the Coast Guard's submissions, and applicable law:

1. The Board has jurisdiction concerning this matter pursuant to section 1552 of title 10 of the United States Code.

2. Under 10 U.S.C. § 1552(b), an application to the Board must be filed within three years after the applicant discovers the alleged error or injustice. The applicant in this case filed his application more than three years after he was discharged and received his DD-214. Therefore, the application is considered untimely.

3. The Board may excuse the untimeliness of an application if it is in the interest of justice to do so. In *Allen v. Card*, 799 F. Supp. 158 (D.D.C. 1992), the court stated that the Board should not deny an application for untimeliness without "analyz[ing] both the reasons for the delay and the potential merits of the claim based on a cursory review"[25] to determine whether the interest of justice supports a waiver of the statute of limitations. The court noted that "the longer the delay has been and the weaker the reasons are for the delay, the more compelling the merits would need to be to justify a full review."[26]

4. In this case, the application was filed more than three years after the statute of limitations expired in November 2011. The applicant has not provided a justification for the delay in filing his application with the Board. Rather, he alleged that he filed his application because the disparity between the 20% rating assigned by the Coast Guard and the 80% rating assigned by the DVA is unjust and preventing his retirement from the Coast Guard at 30% disability. However, the applicant received his DVA rating in July 2009, more than two years

[25] *Allen v. Card*, 799 F. Supp. 158, 164 (D.D.C. 1992).

[26] *Id*. at 164, 165; *see also Dickson v. Secretary of Defense*, 68 F.3d 1396, 1405 n14, 1407 n19 (D.C. Cir. 1995).

before the statute of limitations would have expired, which provided plenty of time for the applicant to submit an application within the statute of limitations once he learned of the disparity. Therefore, and because the Board's cursory review of the merits (below) shows that the applicant's claim cannot prevail, the Board will not excuse the untimeliness of the application or waive the statute of limitations.

5. The Board's cursory review of the merits shows that the applicant's claim cannot prevail. The applicant's medical records clearly show that the applicant was aware of all of the medical conditions he sustained while on active duty. While the IPEB did not determine all of the applicant's ongoing medical conditions to be disabling conditions making him unfit for duty, the applicant was counseled by an attorney and informed of the process for disputing the IPEB's decision and requesting an FPEB hearing, and could have done so. However, the applicant chose to accept the IPEB rating of 20% with severance pay, with the knowledge that he was waiving his right to a formal hearing. Absent evidence of administrative error, violation of law or policy, or willful misconduct on the Coast Guard's part, the Board cannot find that the IPEB rating was erroneous or unjust.

6. The applicant alleged that his 80% disability rating from the DVA proves that the Coast Guard's IPEB erred in assigning him a 20% rating or failing to process him under the PDES. Under 10 U.S.C. § 1201, a PEB assigns disability ratings according to the member's permanent inability to perform the duties of his office, grade, rank, or rating because of physical disability." A PEB rates only those disabilities that render the member permanently unfit for duty.[27] In contrast, under 38 U.S.C. § 4.1, the DVA considers the extent to which *all* of a veteran's "service-connected" disabilities currently render him unable to work in civilian life, whether or not these disabilities rendered the veteran unfit for duty at the time of separation. Therefore, DVA ratings are "not determinative of the same issues involved in military disability cases,"[28] and the fact that the DVA assigned the applicant an 80% combined disability rating retroactive to his date of discharge does not prove that the Coast Guard erred in assigning him a 20% rating.

7. Accordingly, the Board finds that it is not in the interest of justice to waive the statute of limitations because the preponderance of the evidence does not support the applicant's claim that the Coast Guard's disability rating of 20% and medical discharge process were unjust or erroneous.

(ORDER AND SIGNATURES APPEAR ON PAGE)

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[27] COMDTINST M1850.2C, PDES Manual, Art. 2.C.3.a.(3)(a).

[28] *Lord v. United States*, 2 Cl. Ct. 749, 754 (1983); *see Kirwin v. United States*, 23 Cl. Ct. 497, 507 (1991) ("The VA rating [in 1986] is irrelevant to the question of plaintiff's fitness for duty at the time of his discharge in 1978. Indeed, the fact that the VA retroactively applied plaintiff's 100% temporary disability rating only to 1982, and not 1978, gives some indication that plaintiff was not suffering from PTSD at the time of his discharge."); *Dzialo v. United States*, 5 Cl. Ct. 554, 565 (1984) (holding that a VA disability rating "is in no way determinative on the issue of plaintiff's eligibility for disability retirement pay. A long line of decisions have so held in similar circumstances, because the ratings of the VA and armed forces are made for different purposes.").

ORDER

The application of former [redacted], USCG, for correction of his military record is denied.

April 9, 2015

[redacted]